## ACRODYNIA

### CASE REPORT

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STIMULATED by the case report of Dr. J. W. Robinson in the June number of CALIFORNIA AND WESTERN MEDICINE, I am reporting the following cases of acrodynia to impress upon the profession that they are of more frequent occurrence than is thought; and that the diagnosis is frequently missed.

CASE I—R. B., male child, age fourteen months, first seen by me April 22, 1927, with the following history: Up to February had never been ill and had passed a "perfect first year," weighing twenty-one pounds and twelve ounces on his first birthday. In February, anorexia and listlessness appeared. These grew progressively worse and soon an intractible stomatitis appeared. The child's condition grew steadily worse until when brought in he had the following symptomatology: extreme irritability (he was in the reception room about twenty minutes before admission and I could hear a constant wailing), disturbed sleep—the child slept in the knee-chest position and would waken four to five times a night, howling; extreme constipation; marked drowsiness and apathy if not disturbed; loss of use of his legs; low grade temperature of ten days' duration, 100.4 highest; anorexia—taking about six to eight ounces of milk daily; cold, clammy hands and feet.

When undressed and put on the examining table near a window the child immediately flexed thighs on abdomen and put his hands over his eyes—hypotonia and photophobia; his weakness was extreme, for he could not stand on his legs; his body showed scratches indicating a pruritus; muscle tone nil; his mouth showed an ulcerative stomatitis though the teeth were intact; his hands, wrists, feet, and ankles were purplish red and clammy, with rather a clear line of demarcation.

The child's diet had been prescribed as follows: daily one quart of milk mixed with Roman meal gruel; and cod-liver oil, one teaspoonful twice a day.

There is a great deal of discussion as to the etiology of acrodynia, some observers believing it of dietetic origin, and others favoring an infectious causation. My personal belief is that it is a deficiency disease and belongs in the same class with rickets, pellagra, and beri-beri. Holding to this viewpoint I strive to arrange a diet and treatment which will meet any possible deficiency.

The daily diet I prescribe is as follows:

Butter, two tablespoonsful.

One egg-yolk, at least.

Two to three tablespoonsful of beef juice pressed from seared round steak, very rare.

Four ounces of tomato juice.

No milk (following Porter).

Sun bath, increasing time of exposure as rapidly as possible.

Cod-liver oil is omitted temporarily until the appetite is improved and then started.

If possible, give in addition plenty of vegetables, orange juice, and raw cabbage juice.

The child would not eat all I felt necessary and as he had a marked secondary anemia he was given 2 cc. iron cacodylate (Roger) intramuscularly twice a week. The child showed marked improvement after this, appetite picking up, and a progressive though slow gain being made. His hands and feet never reached the vesicular desquamating stage, and he never lost an ounce after the treatment was started. His initial weight was nineteen pounds and eleven ounces; at the end of June his weight was twenty-two pounds and four ounces. At this time he was walking and apparently recovered. On July 12 the child developed pertussis, but went through the attack with no difficulty; on September 6, weighing twenty-four pounds and four ounces. He is bright, active and happy, and apparently normal in every respect.

CASE II—The second case was an advanced case of acrodynia in a 17 months old boy. The diet that this patient had received consisted of one and one-half quarts of milk that had been boiled three minutes. The same change was made in his diet, and in two weeks he had made remarkable progress.

In these patients it is possible that treatment may be commenced at the turning point of the disease and that the patient might have recovered without a change in treatment.

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## A SYPHON BREAST PUMP

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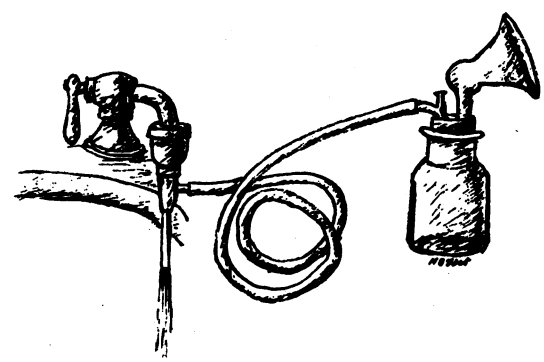
THE mechanical breast pump is a boon to obstetricians and should be more generally used. Expense and bulkiness have heretofore prevented.

The water suction apparatus is not new, but has been used for some time by several men. It is efficient, yet so small and inexpensive that it can be universally used. It consists of a suction pump as used in laboratory practice, a breast cup with collection bottle as used with the electric pump, and a device for releasing pressure. With suction pumps of this kind, pressure has been controlled by pinching off a rubber tube while suction is desired, and releasing it to discontinue the suction. Patients using it have complained of tiring of the fingers from holding the rubber tube. The apparatus here illustrated utilizes also a T tube, but no rubber tubing, using instead an opening which is easily closed by placing over it the finger tip.



To empty the breast, suction is maintained until the flow of milk stops; suction then is released and reapplied. By using a long rubber tube (the heavy variety used for stethoscopes) the pump may be attached, if necessary, to a faucet twenty or more feet from the bed.

The shape of breast cup here illustrated, with the bulb at the center, eliminates pressure on the nipple, thus facilitating free milk flow. It is sold